

MDR Tracking Number: M5-04-1623-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on February 5, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. The special reports, office/outpatient visits, joint mobilization, therapeutic exercises, neuromuscular re-education, manual traction, special supplies, physician medicine procedure, apply neurostimulator, computer data analysis, prolonged service, nervous system surgery, unlisted procedure, subsequent visit, and exercises from 01-31-03 through 04-07-03 were found to be medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On April 20, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
02-06-03	A4556	\$64.00	\$0.00	G	DOP	1996 MFG Rule 133.304(c)	Carrier didn't specify which service A4556 was global to, therefore will be reviewed according to the 96 MFG. Reimbursement recommended in the amount of \$64.00.

03-10-03	99213-MP 97122 97265 97139-EU 97110 64999-22	\$50.00 \$70.00 \$45.00 \$65.00 \$70.00 \$250.00	\$0.00	No EOB	\$48.00 \$35.00 \$43.00 DOP \$35.00/unit DOP	1996 MFG	All services rendered on 03-10-03 were billed by the requestor and denied by the carrier. Neither the requestor nor the respondents submitted EOB's for CPT Codes listed for 03-10-03 therefore, 99213-MP, 97122, 97265, 97139-EU, and 64999-22 will be reviewed in accordance with 1996 MFG. Since the carrier did not provide a valid basis for the denial of these services, reimbursement is recommended in the amount of \$476.00. See rationale below for CPT code 97110.
03-12-03	99080	\$82.50	\$0.00	F	\$.50/pg x 110 pgs	1996 MFG 133.106(f)(3)	99080 will be reviewed in accordance with the 1996 MFG. Recommend reimbursement of \$55.00.
03-17-03	99213-MP 97265 97122 97139-EU 97110 64999-22	\$50.00 \$45.00 \$35.00 \$65.00 \$70.00 \$250.00	\$0.00	No EOB	\$48.00 \$43.00 \$35.00 DOP \$35.00/unit DOP	1996 MFG	CPT codes listed for 03-17-03 were billed by the requestor and denied by the carrier. Neither the requestor nor the respondents submitted EOB's for CPT Codes listed for 03-17-03 therefore, 99213-MP, 97122, 97265, 97139-EU, and 64999-22 will be reviewed in accordance with 1996 MFG. Since the carrier did not provide a valid basis for the denial of these services, reimbursement is recommended in the amount of \$441.00. See rationale below for CPT code 97110.
TOTAL		\$1211.50					The requestor is entitled to reimbursement of \$. 1036.00

Rationale for CPT code 97110 - Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided

as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

This Findings and Decision is hereby issued this 29th day of October 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 01-31-03 through 04-07-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 29th day of October 2004.

Hilda H. Baker, Manager
Medical Dispute Resolution
Medical Review Division
PR/pr

October 26, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT Corrected dates of service in dispute.

Re: Medical Dispute Resolution
MDR #: M5-04-1623-01
IRO Certificate No.: 5055

Dear___:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine who is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

Correspondence
H&P and office notes
Physical therapy notes
Muscle testing reports
Radiology reports

Clinical History:

The records indicate the patient was injured on the job on ___ causing multiple injuries. She was initially taken to the emergency room for evaluation and injuries were present. Over the course of this patient's treatment, she has had an intensive evaluation and diagnostic testing. In addition, she has had extensive treatment over an extended period of time. Diagnostic testing revealed significant positive findings. TWCC sent the patient for a report of medical evaluation, and on March 20, 2003 it was determined that this patient had not reached maximum medical improvement.

Disputed Services:

The following treatment and services during the period of 01/31/03 through 04/07/03:

- Special reports
- Office/outpatient visits
- Joint mobilization
- Therapeutic exercises
- Neuromuscular re-education
- Manual traction
- Special supplies
- Physician medicine procedure
- Apply neurostimulator
- Computer data analysis
- Prolonged service

- Nervous system surgery
- Unlisted procedure
- Subsequent visit
- Exercises

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were medically necessary in this case.

Rationale:

National treatment guidelines allow for this type of treatment for these types of injuries. This is an extremely complicated case with multiple injured areas, which required intensive ongoing care. There is, in fact, proper, adequate, and sufficient documentation that clinically justifies each denied service. In conclusion, it was, in fact, reasonable, usual, customary, and medically necessary for this patient to receive the denied services listed above from 01/31/03 through 04/07/03.

Sincerely,